Pure Resolutions LLC

An Independent Review Organization

Phone Number:
(817) 779-3288

990 Hwy. 287 N. Suite 106 PMB 133
Mansfield, TX 76063
Email:pureresolutions@irosolutions.com

Fax Number:
(817) 385-9613

Notice of Independent Review Decision

Case Number:

Date of Notice: 08/26/2016

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Anesthesiology
Pain Medicine

Description of the service or services in dispute:

Lumbar Facet Block Diagnostic L3-4, L4-L5, Left side 1st

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male diagnosed with low back pain, lumbar facet syndrome, chronic pain syndrome, postlaminectomy syndrome, and reactive depression. On XXXX, the patient was seen for an evaluation regarding continued pain in the lower back, radiating, shooting, tingling, pins and needles, shooting, stinging, and aching. The patient rated the pain from a 0/10 to 5/10. The physical examination revealed normal reflexes of the lumbar spine. Additionally, there was tenderness on the left greater than right at L3-4, L4-5, and L5-S1 with pseudodermatomal radiation. The treatment plan included renewal of medications and followup visits.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The Official Disability Guidelines recommend diagnostic facet joint injections for patients with low back pain that is nonradicular at no more than 2 levels bilaterally. There should be documented evidence of fail/lure of conservative treatment including home exercise, physical therapy, and NSAIDs for a duration of at least 4 to 6 weeks prior to the procedure. The clinical information indicated the patient has completed previous treatment with TENS unit, medications, and surgical intervention. However, there was a lack of documentation with evidence of failed conservative treatment including physical therapy and home exercise program for a duration of at least 4 to 6 weeks prior to the requested injection. In addition, there was no indication of anticipated surgical procedure to warrant the need for diagnostic injection. As such, the request is not supported. Therefore, the request is non-certified and the prior determination is upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)